Summary of Benefits: EPO Program

EPO Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges Preferred Provider (In-Network) [1,2]
Calendar Year Deductible [1] (Family deductible is an aggregate of three times the Individual amount and may be met by three or more family members.)	$150 Individual/ $450 Family
Calendar Year Out-of-Pocket Limit [2] (Includes deductible, copayments, and percentage coinsurance amounts **except** residential treatment center and drug plan copayments. Family limit may be met by three or more family members.)	$2,000 Individual/ $6,000 Family
Lifetime Maximum Benefit Limit (per member)	Unlimited
Office Visit/Exam Charge Office Visits/Exams or Consultations (Other office services received during the visit, unless specified otherwise, are subject to deductible, copayment, and/or coinsurance provisions as listed in the rest of the summary. Includes initial visit to OB/Gyn or midwife to confirm pregnancy; pre-natal and post-natal care is listed under "Hospital/Other Facility: Inpatient" as part of global delivery fee.)	$20/visit *(deductible waived)* [4]
Family Planning: Office visit Sterilization/surgery (reversal not covered); other related services in office (IUD, diaphragm, Depo-Provera)	$20/visit *(deductible waived)* 10% after deductible
Allergy Injections (only) and Immunizations (only)	No copay (*deductible waived)*
Other Allergy Care (such as allergy testing; extract preparation)	10% after deductible
Lab, X-Ray, and Other Diagnostic Tests (nonroutine/nonpreventive)	10% after deductible [4]
Therapeutic Injections; Office Surgery and Supplies	10% after deductible [4]
Nutritional Counseling (**3 sessions/life** for certain conditions)	$20/visit *(deductible waived)*
Routine/Preventive Well-Baby Care (Through Age 2): Including routine checkups; immunizations; routine screenings; routine testing	No Copay (*deductible waived)*
Routine/Preventive Well-Child Care (Ages 3-18): Including routine physicals and exams, well-child care; immunizations, routine vision/hearing screenings	$20/visit *(deductible waived)*
Routine/Preventive Adult Care (Ages 19 and Older): Including routine adult physicals and gynecological exams, colonoscopies, immunizations	$20/visit *(deductible waived)*
Routine/Preventive Lab, X-Ray, Other Testing (Ages 3 and Older): Including routine Pap tests, mammograms, cholesterol tests, urinalysis, EKGs, etc.	No Copay (*deductible waived)*
OTHER MEDICAL/SURGICAL SERVICES	
Acupuncture (limited to **20 visits**/year)	$20/visit *(deductible waived)*
Ambulance: Emergency Transport (Air/ground ambulance, as needed)	10% after deductible[3]
Ambulance: Nonemergency Transfer, Medically Necessary	10% after deductible[4]
Cancer/Congenital Heart Disease Care (Blue Distinctions programs only, which include a food/lodging per diem benefit of **$50** per person, or $100/day for 2-3 persons. Travel and the above per diem allowances combined are limited to **$10,000** per lifetime for each program utilized. If program is not used, benefits are same as for any other service, based on place of treatment, provider, and type of service.)	10% after deductible[4,5]
Cardiac Rehabilitation, Outpatient/Office	$20/visit *(deductible waived)* [4]
Dental/Facial Accident[3], Oral Surgery, TMJ/CMJ Services (for limited, non-dental medical conditions; see a benefit booklet for details)	Usual benefit based on type/place of service[3,4,5]
Emergency Room Visit (*emergency* condition only)	$75/visit *(deductible waived)* [3]
Physician and Other Professional Provider Charges	10% after deductible [3]
Hearing-Related Services -Office exams and evaluations; cochlear implant surgery and auditory testing -Hearing aid services (maximum benefit of **$2,200** during 36-month period, including fitting of hearing aid and ear molds)	10% after deductible 10% after deductible

This is a summary ONLY of benefits available under the EPO Medical Program. Conditions of coverage, limitations, and exclusions apply. See a benefit booklet for details.

IMPORTANT: Except under limited circumstances, nonemergency services must be received from a BCBS Preferred Provider in order to be covered. See "Note" on last page.

EPO Medical Program Covered Services and Limitations (continued)	**Member's Share of Covered Charges** **Preferred Provider (In-Network) [1,2]**
Home Health Care/Home I.V. Services (Private duty nursing **not** covered; care must be from a licensed home health care agency)	10% *(deductible waived for non-nursing services)* [4]
Hospice Services including bereavement counseling when such services are provided by a hospice (Lifetime benefit for hospice limited to **$7,400;** respite care limited to **10 days** for each 6-month benefit period.)	10% *(deductible waived)* [4]
Hospital/Other Facility Services: Inpatient	
- ***Medical/Surgical Facility Acute Care, Observation, Medical Detox, Maternity-Related*** (including routine newborn nursery charges), *and* ***Extended Stay (Nonroutine) for Covered Newborn:*** Room and Board and Covered Ancillaries	10% after deductible[5]
- ***Birthing Center***	10% after deductible
- ***Skilled Nursing Facility*** and *Inpatient* ***Physical Rehabilitation*** (combined max. **100 days**/calendar year)	10% *(deductible waived)* [5]
- *Inpatient* ***Physician's Medical Visit*** *or* ***Consultation***; *Routine Inpatient* ***OB/Gyn Global Delivery Fee*** (includes pre-natal/post-natal care); *Inpatient Newborn Male* ***Circumcision***	No copay *(deductible waived)*
- *Inpatient* ***Surgeon, Anesthesiologist, Radiologist, Pathologist,*** *and* ***Assistant Surgeon*** (including maternity services not part of OB/Gyn global delivery fee and all complications of pregnancy, such as C-section)	10% after deductible
Hospital/Other Facility: Outpatient/Ambulatory Surgery Center (Includes covered services, whether billed by facility or professional provider, including surgery , diagnostic tests, chemotherapy, dialysis, and radiation treatment.)	10% after deductible[4]
Lab, X-Ray, and Other Diagnostic Tests (nonpreventive) Including MRI, CT Scans, and PET Scans; EKGs, etc.	
- *Office or Freestanding/Independent Facility*	10% after deductible[4]
- *Outpatient Hospital*	10% after deductible[4]
Short-Term Rehabilitation, Outpatient/Office (Includes physical, occupational, and speech therapy services, each of which is limited to **20 visits**/ calendar year. Speech therapy is limited to specified medical conditions; see a benefit booklet for details.)	$20/visit *(deductible waived)* [4]
Spinal Manipulation/Osteopathic Manipulation (Max. **20 visits**/ calendar year)	$20/visit *(deductible waived)*
Supplies, Durable Medical Equipment, Prosthetics, Orthotics (Includes insulin pumps and pump supplies. Support hose limited to **6** pair/year. Mastectomy bras limited to **3/**year. For diabetic supplies such as needles, test strips, glucagon, etc., see drug plan provision.)	10% after deductible [4,6]
Surgery: Outpatient Hospital, Ambulatory Surgery Facility, or Office (including facility charges and related physician and other professional charges, such as surgeon, pathologist, radiologist, etc.)	10% after deductible [4]
Therapy: Chemotherapy, Dialysis, and Radiation	
- *Office or Freestanding Clinic*	$20/visit *(deductible waived)* [4]
- *Outpatient Hospital*	10% after deductible[4]
Transplant Services: Limitations apply to donor charges and travel, food, and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network for the transplant provided. Benefits for bone marrow/stem cell donor search limited to **$25,000** in a lifetime.	10% after deductible[4,5]
Travel, Food, and Lodging: Benefits are available when these services are related to case-managed Cancer Services, Congenital Heart Disease, and Transplant Services if patient is receiving treatment from a Blue Distinctions Center for Specialty Care. Travel of more than 50 miles must be necessary in order to be eligible for coverage under this provision.	
Travel to and from health care facility plus per diem payments listed below	$10,000/lifetime after deductible [4]
Food and lodging **per diem** for patient and/or companion(s)	$50/individual or $100 for 2-3 persons after deductible[4]
Urgent Care Facility	$20/visit (deductible waived)
- Ancillary Services (lab tests, x-rays, supplies, etc.)	10% after deductible

Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred providers will not charge you the difference between the covered charge and the billed charge for covered services.

BEHAVIORAL HEALTH: Mental Health and Chemical Dependency	
Mental Health Services	
- *Office, Outpatient, Intensive Outpatient Programs (IOP)*	$20/visit *(deductible waived)* [4]
- *Inpatient and/or Partial Hospitalization*	10% after deductible[5]
-Related Inpatient Physician Claims	No copay *(deductible waived)*
Chemical Dependency Rehabilitation	
- *Office, Outpatient, Intensive Outpatient Programs (IOP)*	$20/visit *(deductible waived)* [4]
- *Outpatient Suboxone Treatment*	10% after deductible [4]
- *Inpatient and/or Partial Hospitalization*	10% after deductible [5]
-Related Inpatient Physician Claims	No copay *(deductible waived)*
- *Residential Treatment Center* (max. **130 days**/lifetime), including physician	$250 facility copay plus 20% after deductible [5,7]

DRUG PLAN: Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Specified Vaccines [8]			
Enteral nutritional products, compounded medications, special medical foods, and other drugs require prior approval or benefits will be denied.	**Generic Drug**	**Brand-Name Drug [8]**	
		On Drug List	**Not on Drug List**
Retail Pharmacy/Specialty Pharmacy Programs (up to a 30-day supply or 180 units, whichever is less; benefits include flu, pneumococcal, and Zostavax vaccines for which no copayment is required)	$15	$30	$45
Mail-Order Program (up to a 60- or 90-day supply or 540 units, whichever is less)	$30	$60	$90
Nonprescription Enteral Nutritional Products and Special Medical Foods (up to a 30-day supply per 30-day period; requires prior approval)	$45 retail/$90 mail-order		

FOOTNOTES:

1 All services – excluding items covered under the drug plan – are subject to deductible unless otherwise indicated in the *Summary of Benefits* (i.e., "deductible waived"). When applicable, the deductible must be met before benefit payments are made.

2 After a member (or family) reaches the out-of-pocket limit, the Medical Program pays 100 percent of that member's (or family's) covered charges for the rest of the calendar year (except for items covered under the drug plan and copayments for residential treatment).

3 Initial treatment by a Nonpreferred Provider of a medical emergency is paid. However, follow-up treatment from a Nonpreferred Provider and any other treatment from a Nonpreferred Provider that is not for an emergency is not covered unless listed as an exception in the "NOTE" at the bottom of the page.

4 Certain services are not covered if prior approval is not obtained from BCBSNM (or Mesa Mental Health). A list of services requiring prior approval is in the benefit booklet. Some services may require a written request for prior approval in order to be covered. Nonemergency ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another.

5 Admission review is required for inpatient admissions. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive approval for these individually identified procedures, benefits for any related admissions will be denied.

6 Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

7 Extended care facilities (such as nursing homes and residential treatment centers) are **excluded** from coverage. However, LANS has authorized the Claims Administrator to approve, when used as a cost-effective alternative to inpatient hospitalization, up to 130 days of residential treatment center services for patients being treated for chemical dependency. This is a lifetime maximum that accrues from Medical Program to Medical Program and is the only exception that can be made to the extended care facility exclusion.

8 Prescription drugs and other items covered under the drug plan must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy or Mail-Order Programs. (BCBSNM has contracted with a separate program for administration of your outpatient drug plan benefits.) Some prescription drugs require prior approval before coverage will be available. If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the generic drug copayment.

NOTE: Nonpreferred Provider services may be covered in the following cases only: emergency care; transition of care (up to 90 days); pathologist, anesthesiologist, and radiologist services when member is receiving covered services at a preferred facility; and when a provider belongs to a type that is "unsolicited" (i.e., a type that is not offered a Preferred Provider contract). Also, if you must travel more than 30 miles to find a Preferred Provider and a Nonpreferred Provider is closer, the Medical Program will cover the Nonpreferred Provider services, if eligible. If the providers are essentially equal in distance from your home or office (i.e., within 5 miles of each other), the exception does **not** apply and you must use a Preferred Provider. This exception also does not apply to members living or residing outside the United States. In any case, to receive Preferred Provider benefits for nonemergency services of a Nonpreferred Provider, you must first obtain **prior approval** from BCBSNM (or Mesa Mental Health).